

Complete This Side For Gonorrhea, Syphilis, or Chlamydia**CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD****PATIENT INFORMATION**

Name:		DOB:	
Address:		Phone:	
City:	County:	Zip:	
Age:	Sex: M F	Race: White Black American Indian Asian Hispanic Unknown	

SPECIMEN COLLECTION/CLINICAL DIAGNOSIS

Name of Lab Performing Test: MTPHL or :	
Date Lab Specimen Collected:	Date Lab Report Received:
Date Reported to Health Department:	Reporting Source to Health Department:
Patient Diagnosis:	PID: Yes No
Health Care Provider:	Phone:
Provider's Address:	

PATIENT TREATMENT INFORMATION

Date:	Med:	Dose:	Duration:
Date:	Med:	Dose:	Duration:

CONTACT INTERVIEW

Interviewer:	Date:
Interviewing Agency:	

CONTACT INFORMATION

Name of Contact	Sex	Date of Last Exposure	Test Date	Date of Treatment	Disposition Code (See Below)

ADDITIONAL INFORMATION

Was patient counseled about HIV risk?	Yes	No	Date if Known:
Was patient tested for HIV?	Yes	No	Date if Known:

DISPOSITION CODES

- | | | | |
|-----------------------------------|--|--|------------------------|
| A. Preventive Treatment | D. Infected, Not Treated | G. Insufficient Information to Begin Investigation | K. Out of Jurisdiction |
| B. Refused Preventive Treatment | E. Previously Treated for this Infection | H. Unable to Locate | |
| C. Infected, Brought to Treatment | F. Not Infected | J. Located, Refused Examination | |

Comments: _____

Local Health Department Reviewer: _____ ~ New Case ~ Update of prior report	If out of jurisdiction: Case Referred to DPHHS ~ or County ~ _____
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